

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012245

STATE FILE NUMBER

28

FILED APR 20 1959

Registration District No. 15

Primary Registration District No. 3004

Registrar's No.

300

1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BARTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY VERNON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lamar		c. CITY OR TOWN SHELDON 1086	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARTON Co. Hosp		d. STREET ADDRESS (If outside, give location) 3 HRS	
3. NAME OF DECEASED (Type or print) First ANTHONY Middle WAYNE Last RAPP		4. DATE OF DEATH Month 4 Day 12 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		11. BIRTHPLACE (City and state or country) LAMAR MO. 0	
13a. FATHER'S NAME RICHARD BRUCE RAPP		13b. MOTHER'S MAIDEN NAME WONNA M. BORGHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT RICHARD B. RAPP Address SHELDON MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Permaternity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pregnancy due date until June 15 59. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 776X	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Apr 12, 59 to Apr 12, 59 and last saw him alive on Apr 12, 59 Death occurred at 7:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sam T. Bickel, MD (Degree or title)		22b. ADDRESS Lamar, Mo.	
22c. DATE SIGNED 4/13/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-13-59	
23c. NAME OF CEMETERY OR CREMATORY SHELDON MO		23d. LOCATION (City, town, or county) (State) SHELDON MO	
24. FUNERAL DIRECTOR Beeny		25. DATE RECD. BY LOCAL REG. APR 13 '59	
ADDRESS SHELDON MO		26. REGISTRAR'S SIGNATURE Marie Komar	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *L. Gerald Beene*

Licensed Embalmer No. *4203*

P. O. Address *Sheldon Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.